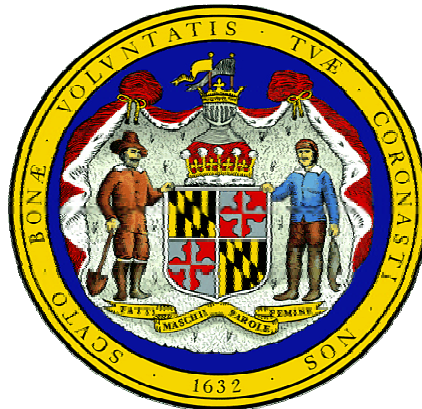


# **An Analysis and Evaluation of Certificate of Need Regulation in Maryland**

## **Working Paper: Intermediate Care Facilities - Mental Retardation (ICF/MR) Services**



### **MARYLAND HEALTH CARE COMMISSION**

Division of Health Resources

4201 Patterson Avenue

Baltimore, Maryland 21215

[www.mhcc.state.md.us](http://www.mhcc.state.md.us)

**October 18, 2001**

**Donald E. Wilson, M.D., MACP**  
**Chairman**

**Barbara G. McLean**  
**Interim Executive Director**

## Table of Contents

---

	Page
<b>I. INTRODUCTION.....</b>	<b>1</b>
A. Purpose of the Working Paper .....	1
B. Invitation for Public Comment .....	1
C. Organization of the Working Paper .....	1
<b>II. DEVELOPMENTAL DIABILITIES: OVERVIEW.....</b>	<b>3</b>
A. Definition of Development Disabilities .....	3
B. Supply and Distribution of Developmental Disability Services .....	4
C. Trends in the Utilization of ICF/MR Facilities .....	10
D. Alternatives to Inpatient Care for Developmental Disabilities .....	11
1. Medicaid Home & Community Based Services (HCBS) Waiver .....	11
2. Residential Services .....	12
3. Day Services .....	13
4. Support Services .....	13
E. Reimbursement Issues .....	14
F. State Quality of Care Initiatives.....	16
<b>III. GOVERNMENT OVERSIGHT OF SERVICES TO THE DEVELOPMENTALLY DISABLED IN MARYLAND .....</b>	<b>19</b>
A. Department of Health & Mental Hygiene (DHMH).....	19
B. Board of Physician Quality Assurance and Board of Nursing.....	19
C. Maryland Health Care Commission (MHCC) .....	20
<b>IV. MARYLAND'S CERTIFICATE OF NEED REGULATION OF ICF/MRS COMPARED WITH OTHER STATES.....</b>	<b>21</b>
<b>V. ALTERNATIVE REGULATORY STRATEGIES: AN EXAMINATION OF CERTIFICATE OF NEED POLICY OPTIONS.....</b>	<b>22</b>
A. Option 1: Maintain Existing Certificate of Need Program Regulation.....	22
B. Option 2: Deregulation from Certificate of Need Review, with Approval by the Developmental Disabilities Administration of Any New Facilities .....	22

## I. INTRODUCTION

---

### ***A. Purpose of the Working Paper***

With the 1999 passage of House Bill 995<sup>1</sup>, the General Assembly required the Maryland Health Care Commission to examine the major policy issues of the Certificate of Need process, and to submit an interim report by January 1, 2001<sup>2</sup>, followed by a final report by January 1, 2002. The Commission embarked upon a two-year process during which it would develop a series of working papers examining specific issues and implications of changes to the CON model of regulation. Intermediate care is one of the medical services defined in Commission statute, at Health-General Article 19-123(a), as requiring a Certificate of Need to establish, and in some cases, to expand once established. One category of intermediate care facility is licensed as “ICF/MR” and applies to facilities that provide residential treatment to individuals with mental retardation or developmental disabilities. This report examines the current policy and regulatory issues affecting intermediate care facilities for persons with mental retardation, and outlines several alternative options for changes to the Certificate of Need program and their potential implications.

### ***B. Invitation for Public Comment***

The Commission invites all interested organizations and individuals to submit comments on the options presented in this working paper. Written comments should be submitted no later than Monday, November 19, 2001 to:

Barbara G. McLean, Interim Executive Director  
Maryland Health Care Commission  
4201 Patterson Avenue, 5<sup>th</sup> Floor  
Baltimore, MD 21215-2299  
Fax: 410-358-1311  
E-Mail: [bmclean@mhcc.state.md.us](mailto:bmclean@mhcc.state.md.us)

### ***C. Organization of the Working Paper***

This paper is organized in four major sections. Following this introduction, Part II of the paper contains an overview of mental retardation services provided in intermediate care facilities in Maryland, which characterizes the service according to its various settings, and provides both an inventory of existing providers and data on utilization trends. In addition, this section will address alternatives to inpatient care for mentally retarded individuals as well as reimbursement issues. Part III describes the functions of the state government agencies with regard to their authority over inpatient mental retardation services, and Part IV describes how other States across the country with Certificate of Need programs regulate inpatient mental retardation services. Part V of the paper outlines alternative regulatory strategies for the State of Maryland

---

<sup>1</sup> Chapter 702, Acts of 1999.

<sup>2</sup> *An Analysis and Evaluation of Certificate of Need Regulation in Maryland: Phase 1 Report to the General Assembly*, available on the Commission’s website, [www.mhcc.state.md.us](http://www.mhcc.state.md.us).

that include continuing, changing, or discontinuing Certificate of Need regulation of these services. The options identified reflect different assumptions about the role and ability of government, and of the market for health care services, to rationally allocate a crucial service and to protect the public interest.

## II. Developmental Disabilities: Overview

---

### A. *Definition of Developmental Disabilities*

The Annotated Code of Maryland<sup>3</sup> defines “developmental disability” as a “severe chronic disability” that:

- Is attributable to a physical or mental impairment, other than the sole diagnosis of mental illness, or to a combination of mental and physical impairments;
- Is manifested before the individual attains the age of 22;
- Is likely to continue indefinitely;
- Results in an inability to live independently without external support or continuing and regular assistance; and
- Reflects the need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services that are individually planned and coordinated for the individual.

Mental retardation is defined, in the same law, as “a developmental disability that is evidenced by significantly subaverage intellectual functioning and impairment in the adaptive behavior of an individual.”

Federal law presents very similar definitions of these two terms. Public Law 103-230, the Developmental Disabilities Assistance and Bill of Rights Act defines “developmental disability” as a severe, chronic disability of an individual 5 years of age or older that:

- Is attributable to a mental or physical impairment or combination of mental and physical impairments.
- Is manifested before the individual attains age 22.
- Is likely to continue indefinitely.
- Results in substantial functional limitations in three or more of the following areas of major life activity--
  1. self-care;
  2. receptive and expressive language;
  3. learning;
  4. mobility;
  5. self-direction;
  6. capacity for independent living;
  7. economic self-sufficiency; and
  8. reflects the individual’s need for a combination and sequence of special, interdisciplinary, or generic services, supports, or other assistance that is of lifelong or extended duration and is individually planned and coordinated, except that such term, when applied to infants and young children means individuals from birth to age 5, inclusive, who have substantial developmental delay or specific congenital or acquired conditions with a high probability of resulting in developmental disabilities if services are not provided.

---

<sup>3</sup> Health-General Article §7-101(e) and (l), Annotated Code of Maryland

In Public Law 101-476, the Individuals with Disabilities Education Act (IDEA) of 1990, federal statute defines “mental retardation” as “significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period that adversely affects a child’s educational performance.”

These terms have been further refined by a number of working definitions used by teaching institutions and national advocacy groups to describe individuals with developmental disabilities and mental retardation. UCLA defines a developmental disability as one “related to certain mental or neurological impairments, originating before a person’s 18<sup>th</sup> birthday, that are expected to continue indefinitely and that constitute a substantial handicap. This includes persons with mental retardation, cerebral palsy, epilepsy, autism, and other handicapping conditions found to be closely related to mental retardation or requiring treatment similar to that required for individuals who are developmentally disabled.”<sup>4</sup> Developmental disabilities may be caused by accident, either at birth or during early childhood, by a genetic disorder, or by an error in development of a particular system (e.g., neurological development). For approximately half of the individuals with developmental disabilities, the cause of the disability is unknown.

The American Association on Mental Retardation (AAMR)<sup>5</sup> states that “mental retardation refers to substantial limitations in present functioning. It is characterized by significantly subaverage intellectual functioning, existing concurrently with related limitations in two or more of the following applicable adaptive skill areas: communication, self-care, home living, social/interpersonal skills, community use, self-direction, health and safety, functional academics, leisure and work.” Mental retardation manifests before age 18. Significantly subaverage intellectual functioning means an IQ score of 70 to 75 or below on a standardized individual intelligence test (e.g., Wechsler Intelligence Scales for Children-Revised, Stanford-Binet, and Kaufman Assessment Battery for Children). Related limitations refers to adaptive skill limitations that are related more to functional applications than other circumstances such as cultural diversity or sensory impairment. Mental retardation has many different etiologies and may be seen as a final common pathway of various pathological processes that affect the functioning of the central nervous system.

### ***B. Supply and Distribution of Developmental Disability Services***

The Developmental Disabilities Administration (“DDA”) is the agency in the Department of Health and Mental Hygiene responsible for providing a coordinated service delivery system that enables individuals with developmental disabilities to receive appropriate services oriented toward the goal of integration into the community. DDA provides its services through a combination of four state residential centers (533 individuals resided in the four centers for FY 2000), and community-based services through some 160 non-profit providers, which served 20,000 persons during FY 2000.

Its website describes DDA as taking the leadership role in building partnerships and trust with families, providers, local and state agencies, and advocates to assure that individuals with

---

<sup>4</sup> [www.mrrc.npi.ucla.edu/ddip/index5.html](http://www.mrrc.npi.ucla.edu/ddip/index5.html)

<sup>5</sup> [161.58.153.187/Policies/faq\\_mental\\_retardation.shtml](http://161.58.153.187/Policies/faq_mental_retardation.shtml)

developmental disabilities and their families have access to the resources necessary to foster growth, including those available to the general public. DDA describes its goals as:

- The empowerment of all individuals with developmental disabilities and their families to choose the services and supports that meet their needs.
- The integration of individuals with developmental disabilities into community life to foster participation.
- The provision of quality supports, based on consumer satisfaction, that maximizes individual growth and development.
- The establishment of a fiscally responsible, flexible service system that makes the best use of the resources that the citizens of Maryland have allocated for serving individuals with developmental disabilities.<sup>6</sup>

Under the State's framework of establishing eligibility, DDA will find a person eligible for a full range of services if he or she has a severe chronic disability that:

- Is attributed to a physical or mental impairment, other than the sole diagnosis of mental illness, or to a combination of mental and physical impairments;
- Is manifested before the individual attains the age of 22;
- Is likely to continue indefinitely;
- Results in the inability to live independently without external support or continuing and regular assistance;
- Reflects the need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services that are planned and coordinated for that individual.<sup>7</sup>

For an individual seeking support services only, this person is eligible if he or she has a severe chronic disability that:

- Is attributed to physical or mental impairment, other than the sole diagnosis of mental illness, or to a combination of mental and physical impairments.
- Is likely to continue indefinitely.<sup>8</sup>

Maryland's ICF-MR facilities, or State Residential Centers ("SRCs"), are established in DDA under §7-501 of the Health-General Article of the Annotated Code of Maryland. Their mandate is to provide direct service only to individuals with mental retardation who need 24-hour care and assistance, and have been admitted to the facility while attempts are made to integrate these individuals into less restrictive community settings. Individuals with developmental disabilities who do not have mental retardation are not eligible for admission to one of the four State Residential Centers. Each SRC is required to maintain federal certification as an Intermediate Care Facility for Individuals with Mental Retardation ("ICF-MR") and to comply with all applicable federal and Maryland laws and regulations. SRC services are delivered through a combination of State and federal funds.

---

<sup>6</sup> [www.dhmd.state.md.us/dda\\_md/aboutdda.html](http://www.dhmd.state.md.us/dda_md/aboutdda.html)

<sup>7</sup> [www.dhmd.state.md.us/dda\\_md/aboutdda.html](http://www.dhmd.state.md.us/dda_md/aboutdda.html)

<sup>8</sup> [www.dhmd.state.md.us/dda\\_md/aboutdda.html](http://www.dhmd.state.md.us/dda_md/aboutdda.html)

From FY 1981 through FY 2002, the number of licensed ICF/MR beds and State Residential Centers operated by DDA has significantly decreased, reflecting a continuing movement out of residential institutions and into community-based placements. Table 1 shows that the number of licensed ICF/MR beds decreased from 2,713 beds in FY 1981 to 609 beds by FY 2002, respectively. This is a decrease of 78% in the number of State-operated residential beds for the developmentally disabled population.

The Maryland Health Care Commission regulates the increase or decrease in the number of licensed ICF/MR beds, as well as the establishment or closing of State Residential Centers (SRCs) operated within the State of Maryland. Between 1982 and 1996, the predecessor to the Maryland Health Care Commission, the Health Resources Planning Commission, reviewed eight ICF/MR-related Certificate of Need applications, all of which either requested the delicensure of ICF/MR beds or the closure of a state residential center. The Commission has not received a request for the addition of ICF/MR beds. The following table provides a list of the applications proposing reductions in ICF/MR bed capacity approved under the CON program.



**Table 1**  
**Licensed ICF/MR Bed Capacity and Average Daily Population of**  
**State Residential Centers Operated by Developmental Disabilities Administration**  
**FY 1981 through FY 2002**

<u>Fiscal Year</u>	<u>Number of DDA Operated State Residential Centers (SRCs)</u>	<u>Licensed Capacity of SRCs</u>	<u>Closures of State Residential Centers</u>
1981	10	2,493*	
1982	10	2,408*	DDA closed <i>Ritchie Building @Mt. Wilson Hospital</i> and opened <i>Phillips Building @Crownsville Hospital</i> .
1983	10	2,315*	
1984	10	2,168*	
1985	10	1,924*	DDA closed <i>Phillips Building @Crownsville Hospital</i> .
1986	9	1,753*	DDA closed <i>Henryton Center</i>
1987	8	1,528*	
1988	8	1,442*	
1989	8	1,396	
1990	8	1,676	DDA closed <i>Highland Health Center</i>
1991	7	1,676	DDA closed <i>Inpatient Unit @Walter P. Carter Center</i>
1992	5	1,566	DDA closed <i>Victor Cullen Center</i>
1993	5	1,325	
1994	5	1,325	
1995	5	1,325	
1996	5	1,325	DDA closed <i>Great Oaks Center</i>
1997	4	848	
1998	4	848	
1999	4	705	
2000	4	705	
2001	4	705	
2002	4	609	

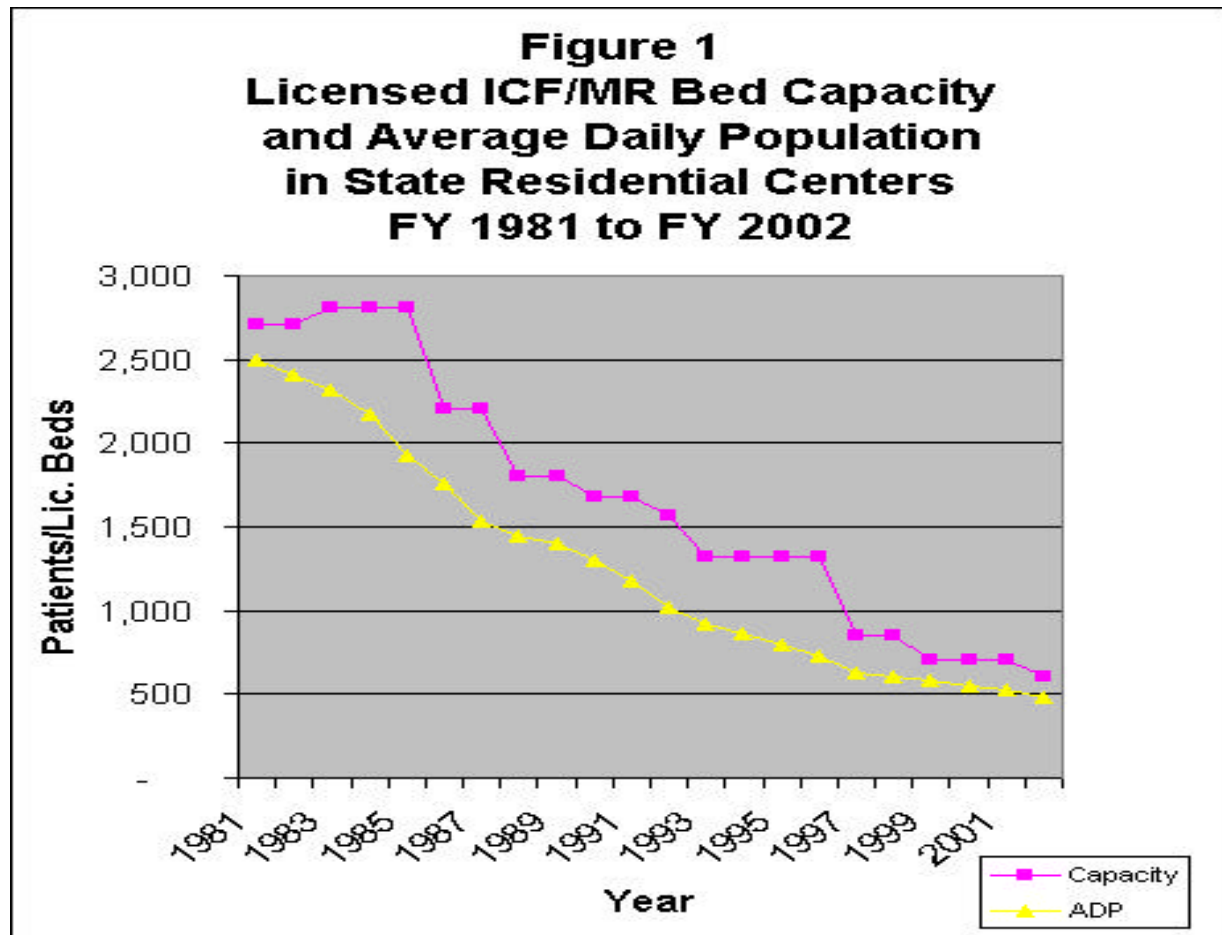
\*Figures reported for FY 1981 through FY 1988 represent the actual average daily population (ADP), as the licensed ICF/MR bed capacity figures for those years are not available.

Source: William Wacker, Assistant Director of Operations, Developmental Disabilities Administration.

**Table 2**  
**ICF/MR Related Certificate of Need Applications:**  
**1982 to Present**

<u>Name of Facility</u>	<u>Docket Number</u>	<u>Project Description</u>
Rosewood Center	82-03-1022	Delicense from 1,250 to 1,125 ICF/MR beds.
Rosewood Center	87-03-1392	Delicense from 1,121 to 605 ICF/MR beds.
Great Oaks Center	88-15-1465	Delicense from 500 to 436 ICF/MR beds.
Rosewood Center	88-01-1505	Delicense 32 bed ICF/MR unit in the Turner Building at Rosewood Center and convert 18 Special Hospital Mental Beds at Finan Center to 18 ICF/MR bed unit at Brandenburg Center.
Great Oaks Center	89-15-1512	Delicense from 436 to 295 ICF/MR beds.
Victor Cullen Center	91-10-1637	Closure of Victor Cullen Center.
Great Oaks Center	96-15-1903	Notice of Closure for Great Oaks Center.
Rosewood Center	96-03-1975	Delicense from 562 to 380 ICF/MR beds.

The following chart shows the decreases in the number of licensed ICF/MR beds as well as in the Average Daily Population experienced in the State Residential Centers from FY 1981 to FY 2002.



Source: Developmental Disabilities Administration

In 1981, DDA operated 10 State Residential Centers in the State of Maryland. From 1982 through 1996, DDA has closed seven programs or facilities serving the developmentally disabled population. From 1982 through 1996, the following programs closed: (1) Ritchie Building at Mt. Wilson Hospital<sup>9</sup> closed in 1982; (2) Phillips Building at Crownsville Hospital in 1985; (3) Henryton Center in 1986; (4) Highland Health Center in 1990; (5) the Inpatient Unit at Walter P. Carter Center in 1991; (6) Victor Cullen Center in 1992; and (7) Great Oaks Center in 1996.

Taking into account that the Phillips Building at Crownsville Hospital opened in 1982 and subsequently closed operation in 1985, DDA presently operates four State Residential Centers in the State of Maryland. The four SRCs are the Joseph D. Brandenburg Center located in Cumberland, the Holly Center in Salisbury, the Potomac Center in Hagerstown, and the Rosewood Center in Owings Mills.

On April 19, 2001, the Developmental Disabilities Administration sought and received the Commission's authorization to further reduce the number of licensed ICF/MR beds operated at the four State Residential Centers. Table 3 provides a breakdown on the decrease in ICF/MR beds at each SRC after this reduction.

**Table 3**  
**Number of Licensed Beds at the Four State Residential Centers**  
**Operated by the Developmental Disabilities Administration**

<b><u>DDA Facility</u></b>	<b><u>Number of Licensed Beds Prior 4/12/01</u></b>	<b><u>Reduction in No. Licensed Beds</u></b>	<b><u>Number of Licensed Beds After Reduction</u></b>
Joseph D. Brandenburg Center	50	5	45
Holly Center	225	30	195
Potomac Center	105	11	94
Rosewood Center	325	50	275
<b>Total</b>	705	96	609

Source: From April 12, 2001 correspondence by DDA to MHCC requesting the reduction in the number of ICF/MR beds at the four State Residential Centers. On April 19, 2001, MHCC issued a determination of non-coverage from Certificate of Need review for the delicensure of these ICF/MR beds.

With the exception of a few court-committed admissions to the Rosewood Center, the overall number of people who are in the four State Residential Centers has declined in recent years. The need for the institutional placement of individuals into an SRC has virtually ceased. Most of the individuals in these four SRCs are adults. SRCs presently provide care to 6-8 children/adolescents at the Holly Center, one person at the Potomac Center, and either 1 or 2 individuals less than 18 years of age at the Rosewood Center. All of these children/adolescents were committed by the court to these institutions. DDA continues to be committed to moving the majority of the individuals in its SRCs into a community-based program.<sup>10</sup>

<sup>9</sup> In addition, DDA opened Phillips Building at Crownsville Hospital in 1982.

<sup>10</sup> The information on recent admissions and current population residing in SRCs is from a telephone conversation with Diane Coughlin, Director of the Developmental Disabilities Administration on September 27, 2001.

The Developmental Disabilities Administration publishes on its website<sup>11</sup> the list of community-based providers operating in the State of Maryland. The DDA divides the State into four Regional offices—Central, Eastern Shore, Southern (which includes the Washington, D.C. area), and Western Maryland. The website lists the name and address of each program, its mission statement, the number of years the program has been in existence, the type of services provided, the type of disabilities each program is capable of serving, the number of individuals currently served, the counties served, the steps an individual must take to apply for the agency's services, and the program's funding sources.

### ***C. Trends in the Utilization of ICF/MR Facilities***

As previously noted, the number of individuals residing in SRCs has declined significantly over the past twenty-two years as the number of individuals served by community-based programs has grown. Since 1981, the average daily population in State Residential Centers has decreased from 2,493 individuals in FY 1981 to 480 people as of August 31, 2001.<sup>12</sup> This figure represents a decrease of 81% in the number of residents during this 22-year period. Over the same time period, as noted above, seven DDA operated institutions have closed, and the four remaining SRCs—Joseph D. Brandenburg Center, Holly Center, Potomac Center, and Rosewood Center--have decreased in size.

On August 31, 2001, there were 480 individuals residing in the four SRCs operated by DDA. Maryland's shift away from institutional services is consistent with national trends over the last several decades. Research supports the belief that the quality of life and advancement of skills for persons with developmental disabilities is greater for individuals who live in the community.

With respect to the current trends in ICF/MR beds, the State of Maryland has ceased new admissions to the four existing SRCs, with the exception of forensic, court-committed admissions at Rosewood Center. DDA has pursued a policy of reducing the reliance on State-operated long-term care facilities in favor of community placement.<sup>13</sup>

In 1999, the Governor's Office for Individuals with Disabilities issued a report called *Moving People with Disabilities to the Community with Appropriate and Quality Supports*, which recommended that 243 people move out of State Residential Centers between fiscal years 2002 through 2004. The DDA has been charged with coordinating this movement in a way that will maximize savings by directing these funds to serve the people residing in the community. Specifically, the Report calls for 65 persons to move-from SRCs into the community in FY 2002, 81 people in FY 2003, and 97 people in FY 2004, and urges that state funds be allocated to accomplish this goal. As the capacity of community-based programs is enhanced, DDA will consider whether additional individuals may be successfully moved to the community.

---

<sup>11</sup> [www.dhmd.state.md.us/dda\\_md/providers.html](http://www.dhmd.state.md.us/dda_md/providers.html)

<sup>12</sup> From William Wacker, Assistant Director of Operations, Developmental Disabilities Administration.

<sup>13</sup> Final Report of the Community Access Steering Committee to Governor Parris N. Glendening, July 13, 2001, p. 72-3.

There are currently ten states that no longer maintain any large institutions for people with mental retardation/developmental disabilities. All fifty states have decreased the proportion of individuals with mental retardation and developmental disabilities residing in institutions relative to individuals receiving services in the community.<sup>14</sup>

#### ***D. Alternatives to Inpatient Care for Developmental Disabilities***

Individuals in SRCs are considered eligible to move to the community with appropriate supports, unless a person is court committed to remain at the SRC<sup>15</sup> or chooses to do so. An individual's placement in the community is dependent on the community's ability to provide the necessary supports, not the severity of a person's disability. The eventual living arrangement must reflect the person's preferences and needs (location, setting, housemate, services, degree of freedom, staffing, proximity to family, etc.) and provide the necessary supports and services for the individual.

Each SRC provides assistance to these individuals in identifying the kind of supports and services each needs to successfully live in the community. Each person has a "Person Centered Plan" based on his or her unique needs and preferences.<sup>16</sup> This type of individualized planning occurs at least on an annual basis. At this annual planning meeting, the team discusses the possibility of the individual moving to the community and determines the supports needed for the individual to live in the community (e.g., 24-hour awake supervision, no steps, barrier free, necessary staff training to meet the needs of the individual, etc.). An individual can move when the appropriate support interventions are prepared and funding is made available. In those cases when the individual's inclination or the team recommendation differ from the family's preference for the individual to remain at the SRC, the staff utilizes a consensus building process to address the family's concerns about community placement. Ultimately, the individual's choice or team recommendation for community placement supersedes family preference, unless a family member is the guardian for the individual.

#### **1. Medicaid Home and Community Based Services (HCBS) Waiver<sup>17</sup>**

First authorized by Congress in 1981, the Medicaid Home and Community Based Services (HCBS) Waiver has been an essential part of community services expansion for the developmentally disabled. Maryland's HCBS Waiver has allowed the State of Maryland to obtain federal funds to safely and responsibly place individuals from the institution into the community. The Maryland Waiver was initially established in 1984 to accommodate 716 individuals from the Rosewood and Henryton Centers. Originally, the waiver provided residential placement, day placement and service coordination. Over the years, the range of

---

<sup>14</sup> Final Report of the Community Access Steering Committee to Governor Parris N. Glendening, July 13, 2001, p. 40.

<sup>15</sup> DDA notes that individuals who are court-committed to an SRC have the right to receive supports and services in the least restrictive environment appropriate to their needs and the security conditions of their adjudication.

<sup>16</sup> Final Report of the Community Access Steering Committee to Governor Parris N. Glendening, July 13, 2001, p. 41.

<sup>17</sup> Final Report of the Community Access Steering Committee to Governor Parris N. Glendening, July 13, 2001, p. 38-39.

services has increased from three to a current total of twelve services, which includes respite care, pre-vocational services, supported employment, environmental accessibility adaptations, personal support, 24-hour emergency assistance, assistive technology, adaptive equipment and intensive behavioral management. Since 1984, the waiver has expanded to serve 4,717 people in FY 2000. Individuals must meet the eligibility requirement for full developmental disability status (determined by DDA's regional office working with resource coordination agencies) and financial eligibility based on individual income and assets (determined by the Department of Human Resources) to receive services under the HCBS waiver.

The Developmental Disabilities Administration has a long history of working with consumers, families, providers, and advocates to successfully return individuals with mental retardation to their communities. Over the past twenty-plus years, DDA has shifted its reliance on institutional services by simultaneously developing a wide array of community support providers. The State of Maryland can successfully serve persons with the most severe disabilities in the community by focusing on prevention, interagency collaboration, and coordination coupled with intensive individual planning. With the emphasis on community and family/individual supports, DDA has successfully developed community supports, to a great extent in the family home, to individuals with severe disabilities who were formerly served in large congregate settings in Maryland and out-of-state. With appropriate support, individuals with disabilities including but not limited to profound mental retardation, severe cerebral palsy, cortical blindness, scoliosis, tracheotomies, seizure disorders, chromosomal abnormalities, respiratory disorders, and ventilator dependency, can live in their communities and in many cases within the family home.<sup>18</sup>

The significant expansion of community-based services for the developmentally disabled and mentally retarded population has been supported by residential, day, and support services.<sup>19</sup> The following is a brief description for each of these community-based programs, and the number of people who utilize these services.

## **2. Residential Services**

Available to Medicaid Home and Community Based Services waiver enrollees and to others, residential services provide habilitation programs in community-based alternative living units (ALUs) and group homes located throughout the State. ALUs and group homes are homes in which individuals with developmental disabilities live with necessary support and supervision. ALU homes serve one to three persons while group homes have four to eight persons. Individual Family Care settings provide residential services to children or adults in foster family homes providing habilitation services.

Community Supported Living Arrangements (CSLA) include a full range of community-based supports, including friends and neighbors, that supervise and provide necessary interventions to allow individuals to live in the community. Combined with community

---

<sup>18</sup> Final Report of the Community Access Steering committee to Governor Parris N. Glendening, July 13, 2001, p. 42-3.

<sup>19</sup> Final Report of the Community Access Steering Committee to Governor Parris N. Glendening, July 13, 2001, p. 39-40.

resources and natural supports, these services assist eligible persons to live successfully in the community regardless of the nature or severity of their disability, and allow individuals to receive services from providers of their own choosing. Elements of CSLA are included as waiver covered services and are available to individuals who do not meet the eligibility criteria for enrollment in the HCBS waiver. There are no income eligibility requirements for residential service programs. In FY 2000, 5,112 individuals received a DDA community residential service.

### **3. Day Services**

Available to HCBS waiver enrollees and to others, day services are provided in three major areas: day habilitation, pre-vocational/vocational, and supported employment. Day habilitation programs provide individuals learning/work experience necessary to help one reach maximum independent functioning. Pre-vocational/vocational programs provide work skills necessary for the person to enter the workforce. Supported employment programs provide necessary support in a variety of work settings where persons without disabilities are also employed. In FY 2000, 8,785 individuals received a DDA-funded day service. There are no income eligibility requirements for day service programs.

### **4. Support Services**

DDA has three categories of support service programs serving the State. The following is a brief discussion on each.

*Individual Support Services (ISS)* are for developmentally disabled adults living with family or on their own. This program assists individuals in functioning and remaining in the least restrictive/most inclusive setting possible. Services include respite services, transportation, environmental modifications, adaptive equipment, money management and home skills. While the Medicaid HCBS waiver addresses the same goal, ISS is not a waiver-covered service.

*Family Support Services (FSS)* provides a wide array of services to families with children under the age of 22 who live at home. This service helps the family to adequately care for their child with a disability at home. Services include respite care advocacy, recreational activities, parent support groups, and transportation assistance. Although HCBS waiver services address the same goal, FSS is not a waiver-covered service.

*Behavioral Support Services (BSS)* provide the supports to help individuals with changing and disruptive behaviors to live safely in the community. Elements of BSS are included as waiver covered services and are available to individuals who do not meet the eligibility criteria for enrollment in the HCBS waiver.

Overall, in FY 2000, 9,141 individuals received a support service funded by DDA. Individuals with developmental disabilities, regardless of income level, are eligible for support services.

### ***E. Reimbursement Issues***

At the four ICF/MR facilities operating within the State of Maryland, the average reimbursement payment for ICF/MR beds at each SRC was \$291 per day in FY 1999, \$323 per day for FY 2000, and \$333 per day for FY 2001.<sup>20</sup> This Medicaid per diem payment is all-inclusive, and includes all services provided to the individual in a State Residential Center, including room and board.

Table 4 provides the total Medicaid payments and the per diems paid to each of the SRCs for the time period FY 1997 through FY 2001.<sup>21</sup> Between FY 1999 to FY 2001, the Total Medicaid Payment and the per diem amount paid to each facility has increased annually. During this three-year period, the total payments increased by 11%, from \$53,588,241 to \$59,708,531, whereas the per diem rose by 26% from \$254.09 to \$320.21.

The Department of Health and Mental Hygiene's Medical Assistance Program provides access to a broad range of health care services for eligible low-income Maryland residents. The Medical Assistance program operates in accordance with federal and State law and receives funding from both the federal and State governments. Maryland's Medical Assistance program is designed to assist a target group of recipients in gaining access to needed services.

As noted above, the Medicaid Waiver Program allows individuals, who meet specific medical criteria under a Federally-approved Home and Community-Based Waiver, to waive certain financial criteria that enable individuals to remain in their home or community setting, and still receive medical benefits. The Medicaid Home and Community-Based Services (HCBS) Waiver for Mentally Retarded/Developmentally Disabled Individuals (COMAR 10.09.26)<sup>22</sup>, which began February 1, 1984, provides services for both mentally retarded and developmentally disabled individuals as an alternative to institutionalization. Initially, the waiver was for individuals discharged from ICF/MRs. Since November 1990, the waiver has also been used to divert individuals who meet the institutional ICF/MR level-of-care and seek to remain in the community before ever being institutionalized. Some of the services covered by the MR/DD Waiver include service coordination, residential habilitation, residential option services, day habilitation, respite care, environmental modifications, supported employment, assistive technology and adaptive equipment.

---

<sup>20</sup> From a telephone conversation with Robert Sutton, Chief of DHMH's Division of Reimbursements on September 26, 2001.

<sup>21</sup> From Pat Holcomb, Health Policy Analyst, Health Services Analysis & Evaluation Administration, Department of Health and Mental Hygiene.

<sup>22</sup> Maryland Medical Assistance Program, The Year in Review, Fiscal Year 1997, p. 19.



From FY 1997 to FY 2001, the Medical Assistance Program made the following payments for services rendered under the Medicaid HCBS Waiver program<sup>23</sup>:

**Table 4**  
**Medicaid Payments and Per Diems for State Residential Centers**  
**Operated by Developmental Disabilities Administration**  
**FY1997 Through FY2001**

<u>Facility Name</u>	<u>FY1997</u>			<u>FY1998</u>			<u>FY1999</u>		
	<u>Total Days of Care</u>	<u>Total Medicaid Payment</u>	<u>Medicaid Per Diem</u>	<u>Total Days of Care</u>	<u>Total Medicaid Payment</u>	<u>Medicaid Per Diem</u>	<u>Total Days of Care</u>	<u>Total Medicaid Payment</u>	<u>Medicaid Per Diem</u>
Great Oaks Center*	1,655	\$413,736	\$249.99	0	0	0	0	0	0
Holly Center	67,067	\$17,326,842	\$258.35	62,051	\$15,874,138	\$255.82	58,491	\$15,062,239	\$257.51
Brandenburg Center	18,786	\$4,827,751	\$256.99	16,711	\$4,217,220	\$252.36	15,946	\$4,051,279	\$254.06
Potomac Center	42,051	\$10,837,204	\$257.72	39,723	\$10,035,104	\$252.63	36,217	\$9,202,978	\$254.11
Rosewood Center	103,112	\$26,358,679	\$255.63	101,635	\$25,465,626	\$250.56	100,252	\$25,271,745	\$252.08
<b>Total</b>	<b>232,671</b>	<b>\$59,764,211</b>	<b>\$256.86</b>	<b>220,120</b>	<b>\$55,592,087</b>	<b>\$252.55</b>	<b>210,906</b>	<b>\$53,588,241</b>	<b>\$254.09</b>

\*Developmental Disabilities Administration closed the Great Oaks Center in FY1996.

<u>Facility Name</u>	<u>FY2000</u>			<u>FY2001</u>		
	<u>Total Days of Care</u>	<u>Total Medicaid Payment</u>	<u>Medicaid Per Diem</u>	<u>Total Days of Care</u>	<u>Total Medicaid Payment</u>	<u>Medicaid Per Diem</u>
Holly Center	56,853	\$16,220,165	\$285.30	52,192	\$16,856,031	\$322.96
Brandenburg Center	15,656	\$4,433,684	\$283.19	15,340	\$4,922,917	\$320.92
Potomac Center	33,984	\$9,583,994	\$282.01	31,227	\$9,971,173	\$319.31
Rosewood Center	91,151	\$25,527,298	\$280.06	87,706	\$27,958,410	\$318.77
<b>Total</b>	<b>197,644</b>	<b>\$55,765,142</b>	<b>\$282.15</b>	<b>186,465</b>	<b>\$59,708,531</b>	<b>\$320.21</b>

Source: Pat Holcomb, Health Policy Analyst, Health Services Analysis & Evaluation Administration, Department of Health & Mental Hygiene.  
 Data is from HMFM3730 Report for ICF-MR payments by facility.

<sup>23</sup> From Pat Holcomb, Health Policy Analyst, Health Services Analysis & Evaluation Administration, Department of Health and Mental Hygiene.

**Table 5**  
**Payments for Services Rendered**  
**Under the Medicaid HCBS Waiver Program**

<u>Fiscal Year</u>	<u>Waiver Payments</u>	<u>Percentage Change</u>
FY 1997	\$122,219,892	
FY 1998	\$152,039,126	24.0%
FY 1999	\$144,853,560	-5.0%
FY 2000	\$155,073,354	7.0%
FY 2001	\$190,112,012	22.0%

DDA identifies two barriers that individuals encounter in moving from a State Residential Center to the community. First, direct support wages paid to employees of community-based services are currently inadequate, and fall significantly below the wages paid to those people who work in State Residential Centers for similar work. Because of this disparity in wages, there are a limited number of provider agencies with the expertise to support people with complicated conditions and/or forensic issues.

The second barrier is that the financial funds budgeted for the downsizing of the existing State Residential Centers in FY 2001 and FY 2002 have been reduced. This reduction in funds causes delays in moving people from the SRCs to the community until the end of each fiscal year, and requires resources from other funding categories in order to provide for necessary service add-ons for the individuals who are moving to the community.

#### **F. State Quality of Care Initiatives**

Two of the four State Residential Centers are accredited by The Council on Quality and Leadership in Support for People with Disabilities (“The Council”). The two accredited facilities are the Joseph D. Brandenburg Center in Cumberland and the Potomac Center in Hagerstown, Maryland. The remaining two facilities, Holly Center and Rosewood Center, are not accredited.

The Council is an international, non-profit organization that utilizes personal outcomes as the measure of quality in services and the basis of its accreditation, research, training and consulting services. Located in Towson, Maryland, the Council has accredited 178 facilities in Australia and the United States. This organization provides a continuum of services and resources that increase the effectiveness of individuals, organizations, and systems. The Council accomplishes this mission by working collaboratively with its customers and in partnership with public and private organizations to<sup>24</sup>:

- Develop quality measures, performance indicators, and evaluation methods that are person centered;
- Provide consultation, education, and other learning tools to build individual and organizational capacity;
- Conduct research and promote the availability of data for decision-making and policy development; and

---

<sup>24</sup> [www.thecouncil.org](http://www.thecouncil.org)

- Provide access to the latest information, developments, trends and best practices to self-advocates, the families, support and service organizations, and local, state, and federal organizations.

With the completion of the application process and meeting all accreditation standards, The Council can accredit an institution for a period of one, two, or three years.

The Maryland Office of Health Care Quality (OHCQ) licenses and regulates many community based service providers. These providers include Day Habilitation Services, Family and Individual Support Services, DD Group Homes, Intensive Treatment Programs, and Respite Services in State Residential Centers. In addition to OHCQ's role in licensing and regulating community-based providers, many State agencies and administrations conduct additional quality assurance activities for their community support service programs. For example:

- The Medicaid Program has developed a *Quality Assurance Plan for the Medicaid HCBS Waiver Programs*, which complies with all requirements outlined in CMS' (formerly HCFA) Protocol for Quality Assurance in HCBS Waiver Programs, released on December 20, 2000.
- Medicaid currently uses Inspection of Care (IOC) Teams, comprised of registered nurses and licensed social workers, to evaluate the quality of care provided and assure compliance with regulatory requirements in recipient homes and other community settings.<sup>25</sup>

Since 1994, DDA and the OHCQ have been working with a national consultant to create a comprehensive quality assurance system for individuals with developmental disabilities in Maryland. In 1999, DDA amended regulations to shift focus from process review to measurement of quality outcomes. DDA's quality assurance approach emphasizes protecting health and safety while offering choice and respect, and includes the following initiatives:

- Funding a project through *People on the Go of Maryland* to train self-advocates. This project, entitled "Know Your Rights," began in October 1988.
- Establishing mandatory minimum staff training requirements.
- Providing funding for training.
- Requiring all provider agencies to develop and submit to DDA an internal quality assurance plan.
- Restructuring sanctions for providers allowing the DDA to approach problems of different types and magnitudes with appropriate methods and levels of intervention.
- OHCQ does annual inspections of agencies, currently visiting every site that an agency operates. Additionally, DDA regional office staff does monitoring visits to provider agency sites throughout the year, focusing their efforts on those agencies with more serious deficiencies.
- Providing technical assistance to providers.

---

<sup>25</sup> Final Report of the Community Access Steering Committee to Governor Parris N. Glendening, July 13, 2001, p. 49.

- Implementing a pilot consumer satisfaction survey, Ask Me!, in partnership with the DDA Council and the Arc of Maryland, for the fourth year to find out directly from people who receive DDA funded services their level of satisfaction.<sup>26</sup>

---

<sup>26</sup> Final Report of the Community Access Steering Committee to Governor Parris N. Glendening, July 13, 2001, p. 49-50.

### **III. GOVERNMENT OVERSIGHT OF SERVICES TO THE DEVELOPMENTALLY DISABLED**

---

Government oversight of services to developmentally disabled individuals including facilities, staff and program operation, is principally the responsibility of these agencies: several divisions of the Department of Health and Mental Hygiene, including the Developmental Disabilities Administration, the Office of Health Care Quality, and the Maryland Medical Care Programs, which handles the Medicaid Waiver for the Developmental Disabled populations, as well as the Board of Physicians Quality Assurance and the Board of Nursing. The Maryland Health Care Commission (MHCC) regulates ICF/MR facilities through CON review because “intermediate care” is a CON-regulated medical service, but in practice, DDA performs all planning and budgetary functions related to the 4 State-operated Residential Centers. Although this report focuses on the oversight responsibilities of the MHCC, it is important to consider how services to individuals with developmental disabilities are regulated by other agencies of state government.

#### ***A. Department of Health and Mental Hygiene (DHMH)***

The Office of Health Care Quality is responsible for overseeing the quality of care and compliance with both state and federal regulations in all health-related institutions in Maryland. OHCQ licenses health care facilities and investigates quality of care complaints from the general public and those referred by the public to the Local Health Departments. OHCQ is also responsible for licensing the wide range of community based residential programs, day treatment programs and any other services that must be certified in order to receive reimbursement by Medicare or Medicaid.

The Developmental Disabilities Administration (DDA) is responsible for overseeing the Maryland Public Developmental Disabilities System. DDA has primary planning responsibility for this complex population, with the exception of the ICF/MR facilities, which were incorporated into the State Health Plan in 1988 by legislative action. This Administration has wide responsibility to meet the variety of service needs for the developmentally disabled individuals citizens of Maryland. As part of its system, DDA operates the four State Residential Centers. This Administration also plans for and oversees all community-based residential programs, vocational rehabilitation programs and day treatment services for this population.

#### ***B. Board of Physician Quality Assurance and Board of Nursing***

Health occupation regulatory boards associated with DHMH oversee the licensure of health professionals in Maryland. The Board of Physician Quality Assurance (BPQA) will accept and investigate complaints it receives regarding physicians. The Board of Nursing oversees all aspects of nurse licensure, including the investigation of complaints regarding nurses.

### ***C. Maryland Health Care Commission (MHCC)***

Through the health planning statute, the Maryland Health Care Commission is responsible for the administration of the State Health Plan, which guides decision making under the Certificate of Need program and the formulation of key health care policies; and administration of the Certificate of Need program through which certain health care facilities and services are subject to review and approval by the Commission. The only facilities for developmentally disabled persons covered by CON review are intermediate care facilities, added to the medical services covered by CON by statute enacted in 1988.

The services under this statute give MHCC the responsibility to control:

- Entry to and exit from the market of certain health care facilities,
- Entry to and exit from the market of certain medical services, and
- Certain actions undertaken by health care facilities.

The MHCC tools used to assure that these requirements are met are only applicable to ICF/MRs, which is the licensure category for State Residential Centers. Like all other covered programs, the control is exercised by:

- Certificate of Need - a Commission finding based on criteria in COMAR regulations and in the State Health Plan, including bed or service need projections.
- Exemption from CON - a Commission finding based on criteria in statute that a proposed project (1) is not inconsistent with the SHP, (2) results in a more efficient and effective health system, and (3) is in the public interest.
- Determination of Coverage – in response to a written notification or request from a person or health care facility required by either statute or regulation, the Commission's Executive Director issues a written determination that a proposed project is *not* covered by CON rules, based on existing law and regulation.

The categories of facilities and services subject to CON review are outlined in the health planning statute, at Health-General, Article §19-123. MHCC statute also anticipates instances of market exit that, due to potential adverse impact on access to needed services, requires review and approval by the Commission, although not a full CON review. There is no State Health Plan section governing the review of proposed new ICFs for the care of the developmentally disabled. This reflects the fact that this bed and setting of care has been the entire responsibility of the State, through DDA.

#### **IV. MARYLAND'S CERTIFICATE OF NEED REGULATION OF ICF/MRs COMPARED WITH OTHER STATES.**

---

The American Health Planning Association (“AHPA”) publishes an annual survey of the 36 states and the District of Columbia that still maintain a Certificate of Need program. This survey provides a comparison of which health services are regulated by the CON program in their respective states. AHPA’s survey shows that 25 of the 37 state programs regulate ICF/MR beds through CON review. Commission Staff accessed the AHPA’s email network of state CON programs to determine which of the 25 programs include ICF/MR beds in the scope of their respective Certificate of Need review. Staff requested further information on each state’s current utilization trends and how each regulates these intermediate care beds for the developmentally disabled. The following are the comments from those states that responded to this inquiry.

The state of North Carolina regulates the development of new ICF/MR beds under the CON law. At this time, there are a sufficient number of ICF/MR beds in the state and therefore, no new beds are being approved. The state does not expect any change in this position for some time to come given that there are currently 2,570 ICF/MR beds in state operated facilities and another 2,683 beds in small community based facilities.<sup>27</sup>

Illinois also regulates the development of new ICF/MR beds under the CON law. Similar to North Carolina, there are a sufficient number of ICF/MR beds in use within this state, such that the need for additional ICF/MR beds is not anticipated in the immediate future.<sup>28</sup>

The Kentucky State Health Plan states “no ICF-MR/DD beds to serve persons with mental retardation who need that level of care shall be approved under this plan.” Presently, the state has 1,028 licensed ICF-MR/DD beds.<sup>29</sup>

The state of New Jersey does not regulate ICF/MR beds as to their numbers, nor does the Department of Health and Senior Services license these beds.<sup>30</sup>

In 1987, the West Virginia Legislature placed a moratorium on any additional ICF/MR homes for this state.<sup>31</sup>

---

<sup>27</sup> From email response by Lee Hoffman, Chief, Division of Facility Service, September 19, 2001.

<sup>28</sup> From telephone conversation with Mike Coplin, Division of Facilities Development, Illinois Department of Public Health, September 24, 2001.

<sup>29</sup> From email response by Jayne M. Arnold, Office of Certificate of Need, Cabinet for Health Services, October 2, 2001.

<sup>30</sup> From email response by John Calabria, New Jersey Department of Health, September 14, 2001.

<sup>31</sup> From email response by Dayle Stepp, CON Director, Health Care Cost Review Authority, September 19, 2001.

## **V. ALTERNATIVE REGULATORY STRATEGIES: AN EXAMINATION OF CERTIFICATE OF NEED POLICY OPTIONS**

---

The options discussed in this section represent alternative regulatory strategies to achieve the policies, goals, and objectives embodied in Maryland's Certificate of Need program. Since the State's residential centers operated by DDA represent the only ICF/MR capacity in Maryland, as a practical matter, the alternatives are two. Either the Commission should maintain the ICF-determined CON requirement, to provide oversight during any further downsizing and to carefully review any private sector applicant that may seek to provide ICF services to this vulnerable population. Alternatively, the Commission could clarify the statutory definition of "intermediate care" in its list of CON-regulated medical services, to exclude these facilities. The questions suggested in the guiding principles in the Commission's *An Analysis and Evaluation of Certificate of Need Regulation in Maryland: Study Overview*, provide a framework for the evaluation of these options.

### **A. Option 1: Maintain Existing Certificate of Need Program Regulation.**

This option would maintain the Certificate of Need program as it currently applies to intermediate care beds for the developmentally disabled and the mentally retarded. Under current law, a CON is needed to establish a new facility that provides intermediate care to persons with mental retardation, to increase the number of ICF/MR beds in an existing State Residential Center, or to close any of the SRCs. The most recent CON activity related to ICF/MR beds has been (1) the delicensure of 182 ICF/MR beds at the Rosewood Center and (2) the Notice of Closure for the Great Oaks Center, both of which occurred in 1996. Smaller numbers of beds may be closed through decreases permitted under the waiver rule.

The Developmental Disabilities Administration operates the four publicly operated State Residential Centers treating the residents of the State of Maryland. Presently, there are no privately operated facilities that treat developmentally disabled individuals in an inpatient setting within the State. The recent trend in the SRCs is to move individuals from these facilities into community-based programs that provide the needs and services required for each individual. Future circumstances may create a situation where a privately operated non-profit or proprietary entity would seek to establish an ICF-MR to provide health services to those individuals needing a level of care not available in a community-setting. The CON program would help to ensure that these new operators provide an efficient and cost-effective service appropriate to treat those developmentally disabled individuals needing an intermediate level of care.

### **B. Option 2: Deregulation from Certificate of Need Review, with Approval by the Developmental Disabilities Administration of Any New Facilities.**

The Developmental Disabilities Administration is the lead agency for coordinating the full spectrum of services available to meet the needs of individuals with a developmental disability. DDA's mission is "to assure the full participation of individuals with developmental disabilities and their families in all aspects of community life and to promote their empowerment



to access quality supports and services necessary to foster personal growth, independence and productivity.”<sup>32</sup> Consistent with this mission, DDA has continued over the last two decades to decrease the number of ICF/MR beds, and the number of state residential centers operating within the State of Maryland.

With respect to the future number of licensed ICF/MR beds and the number of individuals expected to move from SRCs into the community, the Governor’s Office for Individual’s with Disabilities issued a recommendation that “DDA incorporate preventive efforts aimed at preventing new admissions to state residential centers.”<sup>33</sup> As a result, DDA plans to move 243 people out of SRCs between fiscal years 2002 through 2004. To accomplish this movement, each of these individuals must have a “Person Centered Plan” developed to meet his or her unique needs and preferences. DDA must have the appropriate community-based support services in place to meet the needs of these individuals.

Throughout this process, the Developmental Disabilities Administration has been responsible for planning and identifying the number of ICF/MR beds that will remain in operation within the four SRCs. The Supreme Court’s decision in *Olmstead* means that DDA will continue to find avenues to move and integrate people residing in state residential centers into the community. This option would allow the Maryland Health Care Commission to focus on the “medical services” identified in COMAR 10.24.01.01A(22), and allow the Developmental Disabilities Administration to make all decisions on the future need for ICF/MR beds.

---

<sup>32</sup> [www.dhmdh.state.md.us/dda\\_md/aboutdda.html](http://www.dhmdh.state.md.us/dda_md/aboutdda.html)

<sup>33</sup> *Moving People with Disabilities to the Community with Appropriate and Quality Supports*, December 1999, p. 3.